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December 15, 2000

IN REPLY REFER TO:  
FILE NO: ALPHA

TO: All Health Care Service Plans

FROM: Brian J. Bartow, Chief, Licensing Division

RE: Compliance with Year 2000 Legislation

**INTRODUCTION.** In September 2000, several items of legislation relating to the Knox-Keene Health Care Service Plan Act as amended<sup>1</sup> (the "Act") were codified. The Department of Managed Health Care ("Department") has identified the information and documents that should be filed by health care service plans ("plans") to demonstrate compliance with the legislation listed below:

AB 525	AB 2130	AB 2903	SB 764	SB 1732	SB 1903
AB 1455	AB 2168	SB 168	SB 1177	SB 1746	SB 2046
AB 1836	AB 2414	SB 265	SB 1471	SB 1814	SB 2094

**INSTRUCTIONS FOR DEMONSTRATING COMPLIANCE.** This memo describes the Department's expectations regarding plan compliance with the 2000 legislation and indicates specific actions we believe are required of plans, including revisions to plan documents and policies and procedures and notifications to providers or enrollees.

- To facilitate plan filings with the Department, we have developed a "Compliance Checklist" that may be used to demonstrate compliance with the specific expectations for implementation, supplemented with supporting documentary evidence as described in Section II (page 9) of this letter. If plans elect to implement legislation using an approach that differs from the expectations outlined in this memo, they should indicate "No" on the checklist and include supplemental information indicating this different approach.
- The documentary evidence requested in Section II of this memo includes exemplar subscriber and provider contracts, evidences of coverage and new or amended correspondence to enrollees and providers. We request that these exemplar documents be submitted in their entirety, with all revisions highlighted in accordance with Section 1352 and Rules 1300.51.3 and 1300.52. In addition, a cover sheet should identify the specific locations in amended documents of the proposed revisions.
- Please file within **30 calendar days** of the date of this letter the Plan's responses to the Department's comments as an amendment with the Health Care Service Plan filing clerk in the

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<sup>1</sup> Health & Safety Code Sections 1340 et seq. References herein to "Section" are to sections of the Act, unless otherwise specifically indicated. References to "Rule" are to the regulations promulgated pursuant to the Act at Title 10 California Code of Regulations, commencing at Section 1300.43.

Department's Sacramento office. Please submit the Plan's responses, including the attached Compliance Checklist, if utilized, under Exhibit E-1. Please submit supporting documentary evidence under the appropriate exhibits.

- Please order the Plan's narrative responses, if any, consistent with the order of the comments below, or consistent with the numbering of the Compliance Checklist. Although a comment may be directed to a specific exhibit or document, please review and revise all other exhibits related to the same issue or subject to ensure consistency.

Questions regarding the Department's comments should be directed to the Plan's respective licensing counsel within the Department.

## I

### COMMENTS REGARDING YEAR 2000 LEGISLATION

#### **AB 525**

AB 525 adds Section 1363.02, which requires plans to include in provider directories, EOCs and disclosure forms a specified statement regarding the availability of family planning and contraceptive services.

*All full service plans should amend their provider directories (including Internet web site provider directories, if any), evidences of coverage ("EOCs") and disclosure forms relevant to affected service areas, to include the statement required by Section 1363.02(b)(1). Affected service areas are those in which any of the Plan's contracting providers limit or restrict any of the following services: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion.*

#### **AB 1455 and SB 1177**

AB 1455 and SB 1177 amend Sections 1367, 1371, and 1371.5, and add Sections 1371.36, 1371.37, 1371.38, and 1371.39 to: prohibit plans from engaging in an unfair payment pattern, as defined, and provide for sanctions; increase the interest rate for untimely payment of an uncontested provider claim to 15% per annum; impose a \$10 charge on plans that fail to automatically include the interest amount in a payment to a provider; require plans to ensure that the provider dispute resolution mechanism ("PDRM") is available to both contracting and non-contracting providers; and require plans to report annually to the Department regarding this provider dispute resolution mechanism.

*All plans should: (1) have a provider dispute resolution mechanism ("PDRM") that is made available to both contracting and non-contracting providers; (2) communicate the availability of the PDRM to contracting and non-contracting providers; and (3) review their claims payment policies and procedures and revise as necessary to ensure compliance with the requirements of AB 1455 and SB 1177, including a mechanism for automatic inclusion in the payment of interest and/or penalty when it is owed.*

### **AB 1836**

AB 1836 amends Civil Code (“CC”) Section 56.10, [Confidentiality of Medical Information Act, (“CMIA”)], and Government Code (“GC”) Sections 27491.1 and 27491.8. The CMIA revisions require plans, providers, and contractors to release confidential medical information to a county coroner in the course of an investigation by the coroner’s office in specified circumstances and authorize disclosure to others in other circumstances.

*All plans should review their policies and procedures relating to the protection and security of confidential medical information and revise as necessary to ensure compliance with AB 1836.*

### **AB 2130**

AB 2130 amends Family Code (“FC”) Section 3751.5 to prohibit denial of enrollment of a child under a parent’s health insurance on any of the following grounds: (1) the child was born out of wedlock; (2) the child is not claimed as an exemption on the parent’s federal income tax return; or (3) the child does not reside with the parent or within the insurer’s service area. FC 3751.5 is also amended to clarify the information that a plan must provide to the non-covered custodial parent of a covered child.

*All plans should: (1) review their underwriting and enrollment policies and procedures, and their subscriber documents, including contracts, EOCs, and disclosure forms, and revise as necessary to ensure compliance with AB 2130, including but not limited to elimination of exclusions, restrictions and limitations that are not consistent with the requirements of AB 2130; and (2) review their policies and procedures relating to the protection and security of confidential medical information and revise as necessary to ensure compliance with AB 2130, including release of specified information to non-custodial parents of covered children.*

### **AB 2168**

AB 2168 amends Section 1374.16 to specify that HIV or AIDS be interpreted broadly as a “condition or disease that requires specialized medical care over a prolonged period of time and is life threatening, degenerative or disabling” in order to maximize an enrollee’s access to a standing referral to a provider who has demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires on-going monitoring. This provision sunsets on January 1, 2004 or sooner upon the adoption, accreditation or designation by a federal or state government agency or by a voluntary national health organization of an HIV or AIDS specialist. Overall, plans must continue to ensure timely access to these specialists.

*All full service plans should (1) review their utilization review processes and revise as necessary to ensure compliance with AB 2168, including development of objective criteria for the determination of which providers have demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires on-going monitoring. (2) review their EOCs and disclosure forms and revise as necessary to ensure that the disclosures regarding the plan’s standing referral process are consistent with the requirements of AB 2168, including information stating how enrollees may obtain a list of the plan’s providers who have demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires on-going monitoring; and (3) communicate to contracting providers the requirements of AB 2168.*

### **AB 2414**

AB 2414 amends CC Section 56.10 and adds a new chapter to the Act, commencing with Section 1399.900, regulating disease management organizations (“DMO”), as defined, and permitting disclosure by a health care provider or a plan to a DMO contracting with a plan to monitor or administer care of enrollees for a covered benefit, provided that the disease management and care are authorized by a treating physician. AB 2414 also prohibits a DMO, as defined, from: (1) engaging in certain activities without prior physician authorization; and (2) soliciting or offering for sale any products or services to an enrollee of a plan while providing disease management services unless, as specified, the enrollee elects to obtain information about these products and services.

*All plans providing or arranging for the provision of disease management services should (1) review their quality assurance and utilization review policies and procedures, and revise as necessary to ensure compliance with the requirements of AB 2414; (2) review contracts, if any, with DMOs and revise as necessary to ensure compliance with AB 2414; and (3) communicate to contracting providers the requirements of AB 2414.*

### **AB 2903**

AB 2903 revises various portions of the Assembly Bills that were part of the HMO reform package of 1999, including amendments to the statutes enacted by the following 1999 legislation: AB 12 (Section 1383.15); AB 78 (numerous sections of the Act and other code sections); and AB 285 (B&P Section 4999).

1. Section 1383.15 is amended to clarify that second opinions must be authorized or denied in a timely fashion not to exceed 72 hours and deletes the word “rendered,” and to expand the definition of an appropriately qualified health care professional to include application to specialized plans.

*All plans should: (1) review their utilization review policies and procedures and revise as necessary to ensure compliance with Section 1383.15, as amended by AB 2903; and (2) review their EOCs and disclosure forms to ensure that the disclosures regarding the second opinion policy are in compliance with Section 1383.15, as amended by AB 2903.*

2. Numerous sections throughout the H&S Code and other codes are amended to change the name of the Department to the Department of Managed Health Care.

*All plans should amend in the normal course of business prior to July 1, 2001 all references to the Department in plan and subscriber documents for consistency with AB 2903.*

3. B&P Section 4999 is amended to require registration with the Telephone Medical Advice Services Bureau a business entity that employs, or contracts or subcontracts, directly or indirectly, with the full-time equivalent (“FTE”) of five or more persons functioning as health care professionals, whose primary function is to provide telephone medical advice (“TMA”). B&P Section 4999(c) clarifies that a medical group that operates in multiple locations within the state is not required to register as a TMA service if no more than five FTE employees at any one location perform TMA services, and the services are limited to patients who receive care at that location. B&P Code Section 4999.7 is amended to define TMA as communication by telephone between a

patient and a health care professional to provide a telephone response to the patient's questions regarding his or her treatment or a family members treatment.

*All plans should review their QA policies and procedures relating to the provision of TMA services to its enrollees and revise as necessary to ensure compliance with B&P Sections 4999 et seq.*

### **SB 168**

SB 168 adds Section 1367.36 to prohibit plans from requiring providers to (1) accept the financial risk for required childhood immunizations that are not part of the current contract and (2) assume this financial risk as a condition for entering the plan-provider contractual arrangement.

*All full service plans should review their provider contracts and their provider contracting policies and procedures, and revise as necessary to ensure compliance with SB 168.*

### **SB 265**

SB 265 adds Article 4.6 (commencing with Section 1366.35) and Article 10.5 (commencing with Section 1399.801) establishing state law and oversight pursuant to the Federal Health Insurance Portability and Accountability Act. SB 265 reforms the individual coverage market: prohibiting plans from denying coverage to a "federally qualified defined individual;" prohibiting imposition of pre-existing condition exclusions if a person meets specific criteria; setting premium limits; and requiring plans participating in the individual market to fairly and affirmatively offer, market and sell individual policies consistent with SB 265 by January 1, 2001.

*All plans that provide coverage under individual contracts should review their individual subscriber contracts, and their underwriting, contracting and marketing policies and procedures to ensure compliance with SB 265.*

### **SB 764**

SB 764 repeals the provisions in the Act, commencing with Section 1358.1, regulating Medicare supplement contracts issued by plans, and enacts other similar provisions that closely follow the National Association of Insurance Commissioner's (NAIC) Model Regulation to implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, which incorporates Federal legislative changes to Medicare Supplemental Insurance enacted in the Federal Balanced Budget Act of 1997. The provisions establish benefit standards for various coverage options offered under the contracts and impose disclosure, marketing, and report requirements on health care service plans that offer these contracts.

*All plans providing coverage under a Medicare supplement contract, Medicare Plus Choice contract or Medicare Risk contract should review all such subscriber contracts, and their contracting, underwriting and marketing policies and procedures and revise as necessary to ensure compliance with SB 764, reflecting also compliance with the amendments to Sections 1358.11 and 1358.12 pursuant to SB 1814. (Please see the Department's comments regarding SB 1814, below.)*

**SB 1471**

SB 1471 adds CC Sections 3040, et seq., limiting the amount of a lien for the recovery of money paid for medical services provided to an enrollee that may be asserted by a plan, or by a medical group or IPA to which a health plan has delegated or granted lien rights.

*All plans that assert or delegate such lien rights or contract with providers that may assert such lien rights should: (1) review all subscriber contracts, EOCs and disclosure forms and revise as necessary to ensure compliance with SB 1471, including the elimination of any exclusions, limitations, or restrictions that are inconsistent with the requirements of SB 1471; (2) review all provider contracts, provider operations manuals, and third party liability policies and procedures, as applicable, and revise as necessary to ensure consistency with SB 1471; and (3) communicate to outside vendors responsible for third party liability or collections the requirements of SB 1471. The plan's provider contracts and EOCs should reflect (1) whether the plan delegates to a provider the plan's lien rights, and (2) that contracted providers will accept the plan's payments on behalf of the enrollee and will not assert against the enrollee statutory or other lien rights that may exist.*

**SB 1732**

SB 1732 amends B&P Section 511.1 and H&S Section 1395.6, relating to leasing of provider networks, to amend the definition of "payer" and "contracting agent" and to add the definition of "beneficiary."

*All plans that sell, lease, assign, transfer or convey their respective lists of contracted providers to a payer or contracting agent, as defined, should review their relevant policies and procedures and provider contracts, and revise as necessary to ensure to demonstrate compliance with SB 1732.*

**SB 1746**

SB 1746 amends Section 1373.65 to require plans to notify enrollees upon the termination of a primary care provider ("PCP") in addition to the current requirement to notify enrollees when an individual practice association ("IPA") or medical group is terminated. Section 1373.65(h)(2)(i) states that this section is not applicable to a health care service plan contract that provides benefits to enrollees through preferred provider contracting arrangements if the plan does not require the enrollee to choose a PCP.

*All full service plans should review their quality assurance and continuity of care policies and procedures and revise as necessary to ensure compliance with the requirements of SB 1746. The Plan's policies and procedures should ensure that the required enrollee notification will: (1) occur 30 days before termination for any reason of a contract with a medical group, IPA or PCP; (2) be in writing; (3) be provided to enrollees who are at that time receiving a course of treatment from a provider of a medical group or the IPA or PCP or are designated as having selected that medical group, IPA or PCP for their care. The plan should also develop forms of enrollee notice for use in connection with termination of a PCP or IPA. This notice of PCP/IPA termination should include (1) instructions for selecting a new PCP and (2) disclosure of the opportunity for self-referral under the conditions identified in Section 1373.65(a)(1) if the plan does not have a system for automatic reassignment of PCP or whose enrollees do not otherwise have direct access to a PCP.*

### **SB 1814**

SB 1814 amends the Medicare supplement provisions of the Act enacted by SB 764. SB 1814 is an urgency statute requiring immediate implementation. Section 1358.22(d), effective September 30, 2000, requires that plans subject to the requirements of Section 1358.22 give specified notice to eligible persons, as defined at Section 1358.22(b).

*All plans providing coverage under a Medicare supplement contract, Medicare Plus Choice contract or Medicare risk contract should review policies and procedures relating to termination or cancellation of coverage and revise as necessary to ensure current compliance with the requirements of SB 1814; and (2) develop forms of required notice that the plan will provide to eligible persons, including eligible persons terminating or losing coverage or benefits effective January 1, 2001.*

### **SB 1903**

SB 1903 amends CC Sections 56.10 and 56.11, and adds CC Section 56.07 and H&S Section 123111, to make the CMIA provisions that prohibit the sharing, selling and use of medical information applicable to corporations and affiliates; to allow an adult patient to make a part of his or her patient records a specified addendum; and to require health care providers to attach that addendum to the patient's records.

*All plans should: (1) review their policies and procedures relating to protection and security of confidential medical information and revise as necessary to ensure compliance with SB 1903; (2) communicate the requirements of SB 1903 to its contracted providers; and (3) review its quality assurance policies and procedures and revise as necessary to ensure that the QA system encompasses review of compliance with H&S Section 123111 by its contracting providers.*

### **SB 2046**

SB 2046 amends Section 1367.21 to expand the conditions for which plans must provide coverage of off-label use of prescription drugs to include "chronic and seriously debilitating conditions," as defined, under specified circumstances.

*All plans that offer contracts providing for coverage of prescription drug benefits should (1) review their utilization review policies and procedures and revise as necessary to ensure compliance with the requirements of SB 2046; and (2) review their EOCs and disclosure forms and revise as necessary to ensure that the disclosures related to coverage of off-label use of prescription medications are consistent with Section 1367.21.*

### **SB 2094**

SB 2094 revises various portions of the Senate Bills that were part of the HMO reform package of 1999, including amendments to the statutes enacted by the following 1999 legislation: SB 19 (CC Section 56.10); SB 59 (Sections 1363.5; 1367.01); SB 64 (Section 1367.5; 1367.51); and SB 189 (Section 1374.34).

1. CC Section 56.05 is amended to include the definition of contractors and CC Section 56.10 is amended to clarify that contractors are within the scope of the CMIA. CC Section 56.10 is also

amended to permit disclosure to independent medical review organizations and their reviewers without specific authorization by the patient. CC Section 56.10(c)(5) is amended to state that when public or private licensing or accrediting entities such as the DMHC or its contractors review medical information on site the information cannot be further disclosed in violation of the law.

*All plans should review their policies and procedures related to the protection and security of confidential medical information and revise as necessary to ensure compliance with the requirements of CC Sections 56.05 and 56.10, as amended by SB 2904.*

2. Section 1363.5 is amended to state that the disclosure required by Section 1363.5 must include the policies and procedures that are filed with the Department pursuant to Section 1367.01(b). Section 1367.01(b) requires plans to file a copy of the policies and procedures governing the utilization review process with regards to medical necessity decisions. Section 1367.01(b), and (f) are amended to clarify that the criteria and guidelines used by the plan are developed pursuant to Section 1363.5 (not the principles and processes, as the statute currently reads). Section 1367.01(h)(4) is amended to permit plans to provide communications regarding denials of treatment requests initially by facsimile.

*All plans should review their utilization review and quality assurance policies and procedures and revise as necessary to ensure compliance with the requirements of Sections 1363.5 and 1367.01, as amended by SB 2094.*

3. Section 1367.5, regarding diabetic daycare education, is repealed and Section 1367.51 is amended to clarify that the education and training required by SB 64 includes instructions that will enable diabetic patients and their families to understand the disease process and the daily management of the disease to avoid hospitalization and complication.

*All full service plans should review their quality assurance, continuity of care and utilization review policies and procedures and revise as necessary to ensure compliance with the requirements of Section 1367.51, as amended by SB 2094.*

4. Section 1374.34 is amended to (a) reference the definition of substantial harm in CC Section 3428, which was enacted by SB 21, the health plan liability statute; (b) to include information regarding the final steps of independent medical review ("IMR") previously contained in an incorrectly numbered section (H&S 13933); and (c) clarify what constitutes prompt implementation of the external reviewers' decision that a treatment is medically necessary.

*All plans should review their policies and procedures related to the independent medical review process and revise as necessary to ensure compliance with Section 1374.34, and related provisions, as amended by SB 2094.*

**II**  
**EXHIBITS TO BE FILED**

1. Please file an exemplary form of the Plan's amended provider contract, in its entirety, under Exhibit K-1.
2. Please file an exemplary form of the Plan's amended subscriber group and individual subscriber contract, as applicable, in their entirety, under Exhibits P and/or Q, as applicable.
3. Please file an exemplary form of the Plan's amended evidence of coverage, disclosure form or combined evidence of coverage and disclosure form, as applicable, in their entirety, under Exhibits S, T and/or U, as applicable.
4. Please file exemplary forms of newly developed or amended provider and enrollee correspondence under Exhibits J and/or W, as applicable.

The Department appreciates the collective cooperation and recommendations offered by the plans to date regarding implementation of new legislation. Please continue to monitor the Department's Internet web site at [www.dmh.ca.gov](http://www.dmh.ca.gov) for further information regarding matters of regulatory interest to plans. The Department encourages plans to sign up at the Department's web site for inclusion in the Department's e-mail distribution list to receive automatic notice when new information is posted to the Department's web site.

## COMPLIANCE CHECKLIST REGARDING YEAR 2000 LEGISLATION

**INSTRUCTIONS.** Please respond YES or NO to each of the items in the checklist below. The Plan should answer “YES” if it has performed the stated compliance action or if its systems and processes meet the stated expectation for compliance. The Plan should answer “NO” if it has not performed the stated compliance action or if its systems and processes do not meet the stated expectation for compliance. For each “NO” answer, the Plan should provide a brief explanation with a statement of supporting facts. For example, if the Plan responds that it has not included the statement required by AB 285 in its evidences of coverage, it should explain that none of its contracting providers limit the health care services recited in AB 285.

Please file the completed checklist under Exhibit E-1, together with supporting explanation, as necessary.

Item	Bill	Yes/No	Plan Compliance Action
<b>1</b>	<b>AB 525</b>		The Plan has amended all provider directories, evidences of coverage (“EOCs”) and disclosure forms relevant to affected service areas to include the statement required by AB 525 [Section 1363.02(b)(1)]. Affected service areas are those in which the Plan’s contracting providers limit or restrict any of the following services: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion.
<b>2(a)</b>	<b>AB 1455 SB 1177</b>		The Plan has a provider dispute resolution mechanism that it makes available to contracting providers and non-contracting providers.
<b>2(b)</b>	<b>AB 1455 SB 1177</b>		The Plan communicates to contracting and non-contracting providers the availability of its provider dispute resolution mechanism.
<b>2(c)</b>	<b>AB 1455 SB 1177</b>		The Plan has reviewed its claims payment policies and procedures and has revised them as necessary to ensure compliance with the requirements of AB 1455 and SB 1177, including a mechanism for automatic inclusion in the payment of interest and/or penalty when it is owed.
<b>3</b>	<b>AB 1836</b>		The Plan has reviewed its policies and procedures for the protection and security of confidential medical information and has revised as necessary to ensure compliance with the requirements of AB 1836, including requiring the release of medical information to a county coroner in specified circumstances and authorizing disclosure to others in other circumstances.
<b>4(a)</b>	<b>AB 2130</b>		The Plan has reviewed its underwriting and enrollment policies and procedures and has revised them as necessary to ensure compliance with the requirements of AB 2130, which prohibits denial of enrollment of a child under a parent’s health insurance on any of the following grounds: (1) the child was born out of wedlock; (2) the child is not claimed as an exemption on the parent’s federal income tax return; or (3) the child does not reside with the parent or within the insurer’s service area.
<b>4(b)</b>	<b>AB 2130</b>		The Plan has reviewed its policies and procedures regarding release of confidential medical information and has revised them as necessary to comply with the requirements of AB 2130, which requires plans to release certain information to the non-covered custodial parent of a covered child.
<b>5(a)</b>	<b>AB 2168</b>		The Plan has reviewed its utilization review policies and procedures and has revised them as necessary to ensure compliance with AB 2168, including (1) specifying that HIV or AIDS be interpreted broadly as a “condition or disease that requires specialized medical care over a prolonged period of time and is life threatening, degenerative or disabling, “ and (2) a statement of the Plan’s objective criteria for the determination of which providers have demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires on-going monitoring.

Item	Bill	Yes/No	Plan Compliance Action
5(b)	AB 2168		The Plan has communicated to its contracting providers the requirements of AB 2168.
5(c)	AB 2168		The Plan has reviewed the disclosures in its EOCs and disclosure forms regarding the Plan's standing referral process and has revised as necessary to ensure the disclosure is consistent with the requirements of Section 1374.16, as amended by AB 2168, including information stating how enrollees may obtain a list of the plan's providers who have demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires on-going monitoring.
6(a)	AB 2414		The Plan has reviewed its quality assurance policies and procedures and has revised them as necessary to ensure compliance with the requirements of AB 2414, including limitations on provision of disease management organization services in the absence of a physician authorization and permitting disclosure of information by a health care provider or a plan to a DMO contracting with a plan under specified circumstances.
6(b)	AB 2414		The Plan has reviewed its contracts, if any, with DMOs, and has revised as necessary to include terms sufficient to ensure compliance with AB 2414, including limitations on soliciting and sales of products and services to enrollees.
6(c)	AB 2414		The Plan has communicated to its contracting providers the requirements of AB 2414.
7(a)	AB 2903		The Plan has reviewed its utilization review policies and procedures and has revised as necessary to ensure compliance with Section 1383.15, as amended by AB 2903 including time for utilization management determinations and definitions of appropriately qualified health care professionals.
7(b)	AB 2903		The Plan has reviewed the disclosures in its EOCs and disclosure forms regarding the Plan's second opinion policy and has amended as necessary to ensure that the disclosures are consistent with the requirements of Section 1383.15, as amended by AB 2903, including the definition of an appropriately qualified health professional.
7(c)	AB 2903		The Plan has amended, or will amend in the normal course of business prior to July 1, 2001, all references to the Department in Plan and subscriber documents for consistency with AB 2903.
7(d)	AB 2903		The Plan has reviewed its quality assurance program and has revised as necessary to ensure compliance with AB 2903 in the provision of telephone medical advice services, as defined.
8	SB 168		The Plan has reviewed its provider contracting policies and procedures and has revised as necessary to ensure compliance with SB 168, including prohibiting the Plan from requiring providers to: (1) accept the financial risk for required childhood immunizations that are not part of the current contract; and (2) assume this financial risk as a condition for entering the plan-provider contractual arrangement.
9(a)	SB 265		The Plan has reviewed its marketing policies and procedures and has revised to ensure compliance with SB 265, including prohibiting denial of coverage to a "federally qualified defined individual;" prohibiting imposition of pre-existing condition exclusions if a person meets specific criteria; setting premium limits; and requiring the Plan to fairly and affirmatively offer, market and sell individual policies consistent with SB 265 by January 1, 2001.
9(b)	SB 265		The Plan has reviewed its individual subscriber contracts and revised them as necessary to ensure compliance with SB 265.

Item	Bill	Yes/No	Plan Compliance Action
10(a)	SB 764		The Plan has reviewed its underwriting and marketing policies and has revised as necessary to ensure compliance with SB 764, including the established benefit standards for various coverage options offered under Medicare supplement contracts and the requirements for disclosure, marketing, and reporting regarding these contracts.
10(b)	SB 764		The Plan has reviewed its forms of advertising to be used in connection with the one-time open enrollment period established pursuant to Section 1358.11(d) and has revised them as necessary to ensure compliance with SB 764.
11(a)	SB 1471		The Plan has reviewed its third party liability and lien policies and procedures and revised them as necessary to ensure compliance with SB 1471, including limits on the amount of a lien for the recovery of money paid for medical services provided to an enrollee that may be asserted by the Plan, or by a medical group or IPA to which the Plan has delegated or granted lien rights.
11(b)	SB 1471		The Plan has reviewed its subscriber contracts, EOCs and disclosure forms and has revised them as necessary for compliance with SB 1471, including the elimination of any exclusions, limitations, or restrictions that are inconsistent with the requirements of SB 1471.
11(c)	SB 1471		The Plan has reviewed its subscriber contracts, EOCs and disclosure forms, and has revised them as necessary to disclose that contracted providers will accept the Plan's payments on behalf of the enrollee and will not assert against the enrollee statutory or other lien rights that may exist.
11(d)	SB 1471		The Plan has reviewed its subscriber contracts, EOCs and disclosure forms and has revised as necessary to disclose whether the Plan delegates to providers the Plan's lien rights.
11(e)	SB 1471		The Plan has reviewed its provider contracts, provider operations manuals, as applicable, and has revised as necessary to ensure compliance with SB 1471.
11(f)	SB 1471		The Plan has reviewed its provider contracts, provider operations manuals and third party liability policies, as applicable, and has revised as necessary to include language confirming whether the Plan delegates to a provider the Plan's lien rights, and that contracted providers will accept the Plan's payments on behalf of the enrollee and will not assert against the enrollee statutory or other lien rights that may exist.
11(g)	SB 1471		The Plan has communicated to any outside vendors responsible for third party liability or collections the requirements of SB 1471.
12(a)	SB 1732		The Plan has reviewed its policies and procedures relating to the selling, leasing, assigning, transferring or conveying of the Plan's lists of contracting providers to a payor or contracting agent, as defined, and has revised as necessary to ensure compliance with the requirements of SB 1732.
12(b)	SB 1732		The Plan has reviewed its provider contracts and has revised as necessary to include the disclosures required by SB 1732.
13(a)	SB 1746		The Plan has reviewed its policies and procedures related to provider termination and has revised them as necessary to ensure compliance with the requirements of SB 1746, including giving prior notice to enrollees of termination of an assigned primary care physician ("PCP") or IPA.
13(b)	SB 1746		The Plan has a process for automatically assigning enrollees a PCP on termination of the assigned PCP or the Plan's enrollees otherwise have direct access to a PCP.
13(c)	SB 1746		The Plan's policies and procedures require written notice to enrollees 30 days before termination for any reason of a contract with a medical group, IPA or PCP.

Item	Bill	Yes/No	Plan Compliance Action
13(d)	SB 1746		The Plan's policies require that the notice will be provided to enrollees who, at that time, are receiving a course of treatment from a provider of a medical group or the IPA or PCP or are designated as having selected that medical group, IPA or PCP for their care.
13(e)	SB 1746		The Plan's policies require that the notice to enrollees include instructions on selecting a new PCP.
13(f)	SB 1746		The Plan has developed forms of correspondence for use in giving notice to enrollees as required by SB 1734, which (1) include instructions for selecting a new PCP; and (2) if the plan does not have a process for automatic reassignment of PCP, disclose the opportunity for self-referral under the conditions identified in Section 1373.65(a)(1).
14(a)	SB 1814		The Plan's policies and procedures comply with SB 1814, an urgency statute effective September 30, 2000, requiring plans subject to the requirements of Section 1358.22 give specified notice to eligible persons, as defined at Section 1358.22(b). SB 1814 is applicable to all plans providing coverage under a Medicare supplement contract, Medicare Plus Choice contract or Medicare risk contract.
14(b)	SB 1814		The Plan has developed forms of letters to be used in providing notice to eligible persons, including eligible persons terminating or losing coverage or benefits effective January 1, 2001.
15(a)	SB 1903		The Plan has reviewed its medical information policies and procedures and has revised as necessary to ensure compliance with SB 1903, allowing an adult patient to make a part of his or her patient records a specified addendum and requiring contracting health care providers to attach that addendum to the patient's records.
15(b)	SB 1903		The Plan has communicated to its contracting providers the requirements of SB 1903.
15(c)	SB 1903		The Plan's QA program encompasses review of compliance with H&S Section 123111 by its contracting providers.
16(a)	SB 2046		The Plan has reviewed its utilization review policies and procedures and has revised them as necessary to ensure compliance with the requirements of SB 2046, including "chronic and seriously debilitating conditions," as defined, as expanded conditions for which the Plan must provide coverage of off-label use of prescription drugs under specified circumstances.
16(b)	SB 2046		The Plan has reviewed the disclosures in its EOCs and disclosure forms regarding coverage of off-label use of prescription medications and has revised them as necessary to ensure the disclosures are consistent with Section 1367.21.
16(c)	SB 2046		The Plan has communicated to its contracting providers the requirements of SB 2046.
17(a)	SB 2094		The Plan has reviewed its policies and procedures relating to the protection and security of confidential medical information and has revised as necessary to ensure compliance with SB 2094, including permitting disclosure of medical information to independent medical review organizations and their reviewers without specific authorization by the patient.
17(b)	SB 2094		The Plan has reviewed its policies and procedures relating to disclosure to enrollees, providers and the public of the information subject to Section 1363.5, and has revised as necessary to ensure compliance with SB 2094, including disclosure of the policies and procedures that are filed with the Department pursuant to Section 1367.01(b).

<b>Item</b>	<b>Bill</b>	<b>Yes/No</b>	<b>Plan Compliance Action</b>
<b>17(c)</b>	<b>SB 2094</b>		The Plan has reviewed its policies and procedures and has revised as necessary to ensure compliance with the amendments to Section 1367.01(b), which requires the Plan to file a copy of the Policies and procedures governing the utilization review process with regards to medical necessity decisions.
<b>17(d)</b>	<b>SB 2094</b>		The Plan has reviewed its policies and procedures for developing the criteria and guidelines required by Section 1367.01(b) and (f), and has revised them as necessary to ensure compliance with SB 2904, including requiring that the criteria be developed in accordance with the requirements of Section 1363.5.
<b>17(e)</b>	<b>SB 2094</b>		The Plan has reviewed its utilization review policies and procedures and has revised them as necessary to ensure compliance with Section 1367.01(h)(4), which is amended to permit plans to provide initial communications to providers regarding denials of treatment requests by facsimile.
<b>17(f)</b>	<b>SB 2094</b>		The Plan has reviewed its quality assurance and utilization review policies and procedures, and has revised them as necessary to ensure compliance with SB 2094, including requiring that the education and training required by Section 1367.51 must include instructions that will enable diabetic patients and their families to understand the disease process and the daily management of the disease to avoid hospitalization and complication.
<b>17(g)</b>	<b>SB 2094</b>		The Plan has reviewed its enrollee grievance and related policies and procedures and has revised them as necessary to ensure compliance with the requirements of SB 2094 regarding the final steps of independent medical review, including prompt implementation of the external reviewers' decision that a treatment is medically necessary.